Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HERMANN HOSPITAL
C/O DAVIS FULLER JACKSON KEENE
11044 RESEARCH BLVD STE A-425
AUSTIN TX 78759

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 1

MFDR Tracking Number
M4-98-1930-01

MFDR Date Received
July 31, 1997

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This dispute involves reimbursement under rule 134.400 now void. Carrier has refused reconsideration of reimbursement at fair and reasonable level. Minimum reimbursement should be at the minimum of the Facility Fee Ratio, 85% of billed charges, established by TWCC as fair and reasonable payment for services billed prior to September, 1992."

Amount in Dispute: $**17,193.73**

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The facility is contracted with Liberty Mutual's PPO Healthcare/Compare Affordable. As per the contractual agreement, reimbursement should be made at the lesser of the PPO per diem or the fee schedule allowable less 5%. This stay was paid at the PPO per diem. No additional amount is due . . . Additional reimbursement based on the court decision of 12/6/95 does not appear to be warranted. The inpatient rule was determined void and unenforceable because the Commission failed to satisfy the reasoned-justification requirement of the Administrative Procedure Act. The inpatient per diem rates established by the schedule were not determined unreasonable."

Response Submitted by: Liberty Insurance Corp., 2875 Browns Bridge Road, Gainesville, Georgia 30504

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 24, 1996 to October 25, 1996	Inpatient Hospital Services	$17,193.73	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 *Texas Register* 5210, sets out the reimbursement guidelines for the services in dispute.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. No explanations of benefits or documentation to support the payment exception codes used to reduce or deny the disputed services were submitted for review.

Findings

1. Review of the submitted information found insufficient documentation to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute. Therefore, the disputed services will be reviewed per applicable Division rules and fee guidelines.
2. This dispute relates to inpatient hospital services. The former agency's *Acute Care Inpatient Hospital Fee Guidelin*e at 28 Texas Administrative Code §134.400, 17 *Texas Register* 4949, was declared invalid in the case of *Texas Hospital Association v. Texas Workers' Compensation Commission*, 911 *South Western Reporter Second* 884 (Texas Appeals – Austin, 1995, writ of error denied January 10, 1997). As no specific fee guideline existed for acute care inpatient hospital services during the time period that the disputed services were rendered, the 1991 version of 28 Texas Administrative Code §134.1(f) applies as the proper Division rule to address fee payment issues in this dispute, as confirmed by the Court's opinion in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 96 (Texas Appeals – Austin, 2003, petition for review denied). 28 Texas Administrative Code §134.1(f), effective October 7, 1991, 16 *Texas Register* 5210, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b), until such period that specific fee guidelines are established by the commission."
3. The former Texas Workers' Compensation Act section 8.21 was repealed, effective September 1, 1993 by Acts 1993, 73rd Legislature, chapter 269, section 5(2). Therefore, for services rendered on or after September 1, 1993, the applicable statute is the former version of Texas Labor Code section 413.011(b), Acts 1993, 73rd Legislature, chapter 269, section 1, effective September 1, 1993, which states, in pertinent part, that "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle."
4. 28 Texas Administrative Code §133.305(d)(7), effective June 3, 1991, 16 *Texas Register* 2830, requires that the request shall include "copies of all written communications and memoranda relating to the dispute." Review of the documentation submitted by the requestor finds that the request does not include a copy of any explanations of benefits or medical documentation pertinent to the dispute. The Division concludes that the requestor has not met the requirements of §133.305(d)(7).
5. Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "Minimum reimbursement should be at the minimum of the Facility Fee Ratio, 85% of billed charges, established by TWCC as fair and reasonable payment for services billed prior to September, 1992."
   - The requestor did not submit documentation to support that "Minimum reimbursement should be at the minimum of the Facility Fee Ratio, 85% of billed charges, established by TWCC as fair and reasonable payment for services billed prior to September, 1992."
   - Use of this methodology was rejected in the above-referenced court opinion, *All Saints Health System v. Texas Workers' Compensation Commission*, which stated, in pertinent part, that "As this Court has held in *Methodist Hospitals* [Methodist Hospitals v. *Texas Workers' Compensation Commission*, 874 *South Western Reporter Second 144, 147 (*Texas Appeals – Austin 1994, no writ)], from the time the 1991 Emergency Fee guideline expired, there existed no fee guideline. . . . However, a legal standard for evaluating hospital reimbursements did exist at the time the 1992 fee guideline was adopted—Rule 134.1. Rule 134.1 calls for a case-by-case determination of 'fair and reasonable' reimbursement for cases in which there is no controlling hospital fee guideline. Therefore, the result [of] our 1995 decision was that each hospital reimbursement should be evaluated according to [Labor Code] section 413.011(d)'s definition of 'fair and reasonable' fee guidelines as implemented by rule 134.1 for case-by-case determinations."

- 28 Texas Administrative Code §134.1 requires that "all cost determinations regarding medical fee reimbursements must take into account all of the statutory factors, guaranteeing both cost control and quality of care . . . [and] because reimbursement determinations are necessarily fact specific and made on a a case-by-case basis, no definition could adequately encompass 'the myriad of factual situations' that could arise." *Vista Healthcare, Inc. v. Texas Mutual Insurance Company,* 324 *South Western Reporter Third 264, 272-274* (Texas Appeals – Austin, 2010, petition denied). In addition: "Just because the [1992 Fee Guideline] had been invalidated on procedural grounds does not necessarily mean that the amount paid under the fee guideline on any given claim was not 'fair and reasonable." The Hospitals could have submitted the claims for additional reimbursement with supporting evidence to show the additional amount is fair and reasonable. This they did not do." *Hospitals and Hospital Systems v. Continental Casualty Company*, 109 *South Western Reporter Third 96, 101* (Texas Appeals – Austin, 2003, petition denied). Similarly, the Requestor in this dispute did not provide supporting documentation to demonstrate how its request to receive 85% of its billed charges would constitute fair and reasonable reimbursement under §134.1 as it existed when the services in dispute were rendered.
- The Division finds that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. Such a reimbursement methodology would leave the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs. Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor does not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement for the services in this dispute.
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement for the disputed services.
- The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

6. The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under 28 Texas Administrative Code §133.305. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	November 1, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.